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CLINICAL LECTURES.

THE OPHTHALMOSCOPE IN DISEASES OF THE NERVOUS SYSTEM.

A clinical lecture delivered at the Hospital of the University of Pennsylvania, Jan. 23, 1879.

By WILLIAM F. NORRIS, M.D.

Clinical Professor of Ophthalmology in the University of Pennsylvania.

GENTLEMEN: You will remember that in my two previous lectures, I have described and pictured to you, by means of coloured images projected on the screen, the normal eye-ground, its physiological variations, and the changes produced in it by hemorrhages, embolism, Bright's disease, leucæmia, and syphilis; and today I propose to illustrate and describe to you some of the more common intra-

ocular changes accompanying certain well-marked lesions of the nervous system.

That the eye should be one of the most sensitive indicators of disease in the central nervous system, seems only natural when we consider its close anatomical relations with it, and its rich supply of cranial nerves. The optic nerve and retina are, from a genetic point of view, part of the brain, being, as it were, sprouts from the anterior cerebral vesicle, and besides this, its nerve of special sense, five other cranial nerves are distributed to the eye and its appendages (viz., 3d, 4th, 5th, 6th, and 7th pairs); and three of these (3d, 4th, and 6th) are distributed exclusively to them. Consequently, lesions of these nerves in any part of their course, or at their points of origin in the brain, constantly cause impaired function of the parts to which they are distributed; e. g., palsy, either com-

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plete or partial, of the iris, or of the ciliary muscle, producing irregularities in the pupils and blurred sight—of the external muscles of the eye, causing double vision, inability to open or close the lids—of the fifth nerve giving rise to anaesthesia of the cornea, etc. Moreover, experience shows that many cases of impaired nutrition, inflammation, and atrophy of the optic nerves, are dependent on lesions of the central nervous system. We will pass by for the present those cases where intra-cranial disease does not reveal itself by any visible change in the eye-ground, but which, by affecting the optic tracts, corpora quadrigemina, or cortical centres, produce marked defects in the field of vision (Hemianopsia, Symmetrical Scotomata, Peripheral Limitations), and confine our attention to a few of those cerebral lesions which produce marked changes in the eye-ground.

Double Optic Neuritis.—Many systematic writers have endeavoured to draw a sharp line of demarcation between those forms of neuritis, accompanied by great swelling of the intra-ocular end of the nerve, where the tortuous, dilated veins are seen alternately veiled by, and emerging from the swollen and partly opaque nerve-fibres, as they run down from the bulging disk (now forming a true papilla) to regain the level of the retina; and those forms of neuritis where there is but little swelling of the disks, and the changes on them are limited to increased capillary congestion, and such clouding of the retinal fibres as either obscure or hide its outlines; but although this classification is convenient for description, we constantly find the one condition shading off into the other, and although in typical cases the distinction is easily apparent, it is by no means always possible to distinguish the appearances of the so-called choked disk where the changes are limited to the intra-ocular end of the nerve, from those caused by a descending neuritis—the one form passing at times so gradually into the other, that it is impossible to point out exactly the line of demarcation between them.

Double optic neuritis may be produced by any cause which gives rise to a consid-

erable and long continued increase in the intra-cranial pressure. Thus Aneurism, Hydrocephalus, or Tumour, etc., may all give rise to it, but clinical experience shows that the causes most frequently producing it are intra-cranial tumours and basilar meningitis. In cases of simple choking of the disk, dissection shows that the pathological changes are, for the most part, limited to the intra-ocular end of the nerve, and the absence of a continuous anatomical chain of abnormal tissue between the focus of disease in the brain and the point of most marked change in the optic nerve, has naturally led physicians to cast about for an explanation of it. Graefe, who was the first, since the introduction of the ophthalmoscope, to insist on the frequency with which double neuritis accompanied brain tumour, supposed that it was caused by the back water movement of the venous blood, produced by the increased pressure on the sinuses of the dura mater, and thence transmitted by the ophthalmic to the central retinal veins; the Lamina Cribrosa acting as a multiplier, and increasing by its constriction of the vessels, the oedema, and congestion of the intra-ocular end of the nerve. The anatomical investigations of Seeseman have since shown that the anastomoses between the ophthalmic, orbital, and facial veins, are so free, that it is not at all probable that intra-cranial pressure can thus be transmitted through the veins to the eye-ground.

Benedict has attempted to explain the state of affairs by supposing that a local palsy of the sympathetic is the cause of choked disk; but it is scarcely possible that this palsy should always be limited to the few filaments supplying the intra-ocular end of the nerve, and symptoms of paresis of other branches, such as contraction of the pupil, partial ptosis and flushing of the face, are notoriously absent in such cases. Since Schwalbe and other anatomists have demonstrated the free connection of the lymph space between the pial and dural sheaths of the optic nerve, and the corresponding lymph space in the cranium, the attention of observers has been directed to the possibility of increased quantities of intra-

cranial fluids (lymph, blood, pus) being driven into the space between the nerve sheaths, causing a dropsy of the peripheral end of the nerve, obstruction to its blood circulation, and alterations in its nutrition. According to this theory, owing to increased intra-cranial pressure, partial stasis in the veins, with exudation of the watery parts of the blood into the sub-arachnoid cavity occurs, and this fluid seeking the point of least resistance, finds its way into the lymph space between the outer and inner sheaths of the optic nerves, and by gradual and long continued pressure, causes a dilatation of the peripheral end of the dural sheath, just before it passes into the sclerotic, compressing, at the same time, the pial sheath and the nerve-fibres covered by it.

I will now project on the screen, careful drawings from a case of choked disks, which came under my notice in 1873,¹ when the autopsy showed a sarcomatous tumour of the cerebellum; abundant serous fluid in the subarachnoid space of the brain and spinal cord; pear-shaped dilatation of the outer sheath of the optic nerve, just before it passes into the sclerotic; and markedly swollen disks, which were commencing to undergo atrophy. These pictures, which show first the cerebellar tumour, second the dilatation of the outer sheath of the nerve, third, sections of the nerve, and fourth, teased portions of it, depicting the minute pathological changes in it, will probably give you a more accurate idea of the pathological changes than any verbal description. Similar pathological alterations have been found in many other cases of brain tumour by other observers, and while I am far from asserting that this is the only way in which choked disks can be produced by intra-cranial disease, I do maintain that it is the only method of its production which has been anatomically demonstrated at the present time. Of course local tissue changes in the subvaginal canal or in the sheath of the nerve near its peripheral end, may cause

either by direct pressure or the development of local dropsy, an optic neuritis. As illustrations of such local changes hemorrhages into the subvaginal space, and the development of tumours may be cited, and recently Michel has detailed a case where the autopsy showed the development of tubercle at this point.

As to the frequency with which double optic neuritis occurs in cases of brain tumour, there has been considerable difference of opinion. A few years since some distinguished ophthalmologists gave it as their opinion that optic neuritis was a rare symptom of brain tumour. Thus Becker, at the Heidelberg Congress in 1868, gave it as his opinion "that brain tumours frequently occur without any swelling of the disks," and Schweigger, in his Handbook, in 1871, says, "that choked disks are absent in the majority of cases of brain tumour;" recent statistics, however, prove the contrary. I will only cite here those of Annuske and of Reich, and will regard among these only those cases where there was an ophthalmic examination, during life, of such cases; the former gives 43, and the latter 45, making a total of 88 cases. Of these, in 82 cases (*i. e.*, in 98 per cent. of them), there was double optic neuritis. Moreover, Hughlings Jackson, who has probably the largest individual experience of any observer of the present day, declares that optic neuritis is an almost universal accompaniment of cerebral tumour.

Basilar meningitis, especially the basilar meningitis of tuberculous children, is a frequent cause of optic neuritis. Thus Heinzel gives 33 cases of basilar meningitis in children, of which 27 (81 per cent.) showed either neuritis or consecutive atrophy. Allbutt gives 38 cases of basilar meningitis, out of which 29 (or 76 per cent.) showed changes in the optic disks. We thus see that double optic neuritis becomes a valuable symptom of brain tumour and basilar meningitis.

Such cases of course usually end fatally, from the natural progress of the severe malady causing them; but I have seen occasional cases of basilar meningitis in

¹ Transactions of American Ophth. Soc., 1874. Cases of Optic Neuritis, by W. F. Norris, M.D.

children, where they had escaped with partial or complete atrophy of the optic nerve; and in adults, cases of syphilitic gumma within the cranium, and of cerebro-spinal meningitis where there was marked optic neuritis, and recovery with slight atrophy of the disks. I believe that the number of such cases in which double neuritis occurs, is usually much underestimated, simply because it is not carefully looked for, many taking it for granted that it is not worth while to examine the eye-ground unless there is marked failure of vision. It must, however, be recollected that a very considerable swelling and engorgement of the intra-ocular end of the nerve, is quite compatible with good vision. I have followed a case for months where there was marked choking of the disks, and in which the vision remained good ($\frac{20}{xxx}$);

and Mauthner cites a case where the patient, to the day of his death, retained perfect central vision ($\frac{20}{xx}$). The ophthalmoscope should therefore be used in every case of suspected brain tumour, whether there be failure of sight or not.

Atrophies of the Optic Nerves form a large group of cases arising from very various causes. Of these we will restrict our attention to a few varieties coincident with other nerve lesions.

Atrophy accompanying Locomotor Ataxia.

—The exact percentage of cases in which atrophy of the optic nerves is found with gray degeneration of the posterior columns of the spinal cord, and the stage of the malady in which it may be first observed, is not yet well made out. I am inclined to think that it is a much more frequent accompaniment of the early stages of tabetic disorders than is usually supposed. Here, as in cases of choked disk, the acuity of central vision long remains unimpaired, and without careful and methodical examination, the concentric narrowing of the field escapes detection. It is only when this had advanced to a degree sufficient to incommode the patient, and when the central vision commences to fail, that we find them applying to the oculist for relief; and the

other symptoms of the disease are usually then so far advanced that they are unmistakable. Moreover, like all early stages of atrophy, it easily escapes observation, even when looked for, unless the observer avails himself of the enlargement given by the upright image, and the nicety in distinguishing slight changes of color possible with the weak-light mirror. While I believe this to be the usual course of tabetic atrophy, the observations of Förster and Charcot prove that complete atrophy of the nerves may develop before any other symptoms are manifest. The former relates a case where, for three years, the atrophy of the optic nerves was the sole symptom of the malady, and then unmistakable symptoms of gray degeneration of the posterior columns of the cord developed themselves. The latter cites a case where atrophy of the optic nerves preceded, for ten years, the development of the other symptoms. Of course in these cases where blindness occurs years before the development of the symptoms of locomotor ataxia, they naturally pass from the observation of the specialist. That the cases of degeneration of the optic nerves accompanying locomotor ataxia forms a large percentage of the total number of cases of amaurosis presenting themselves at an eye hospital, is manifest from the observations of Leber, who reports that in 87 such cases taken as they presented themselves at his clinic, 23 (i. e., 26 per cent.), presented ataxic symptoms; and we may fairly presume that the real percentage is higher than this, inasmuch as it is probable, as in the above cited cases of Förster and Charcot, that spinal symptoms would subsequently develop in some of those cases of amaurosis, in which they were not manifest at the date of examination.

Besides the optic atrophy, cases of locomotor ataxia often, in the earlier stages, develop paresis of the third and sixth nerves, causing transient double vision and dilatation of the pupil. A contracted state of the pupils is, however, more frequent, and we often find them unequal in size, responding more promptly to changes in the convergence and accommodation, than to change from light to shadow.

This state of the pupils may possibly be caused by some affection of the cilio-spinal centre of the cord (at the level of the lower cervical and upper dorsal vertebræ), but I believe that no such lesions have at present been demonstrated by autopsy. The frequent degeneration of the optic nerves in these ataxic cases, is indeed difficult to account for, inasmuch as we have not yet been able to demonstrate any anatomical connection between the gray degeneration of the posterior columns of the cord and the similar affection of the optic nerves, the intervening portions of the cerebro-spinal system being often apparently unaffected by it.

Disseminate Sclerosis of the Brain is also frequently accompanied by atrophy of the optic nerves; and, according to Förster, in about 50 per cent. of these cases, trembling movements of the eyeballs (nystagmus) are observable.

The subject of *Hereditary Disease of the Optic Nerves* is a most interesting one. It has long been known that children are occasionally born with atrophic eye-nerves, but within the last few years Mooren and Leber have both called attention to a group of cases of hereditary optic neuritis developing itself in certain families about the twentieth year, not affecting all the members of a generation, but the males more frequently than the females. The subjective symptoms are a cloud in the centre of the field, while peripheral vision remains good. "The patients belong to the so-called neuropathic individuals of Griesinger, and complain of headache, migraine, dizziness, flashes of light, going to sleep" of the limbs, and convulsive attacks; only one, however, had epilepsy.

Atrophies from Alcohol and Tobacco, in their earlier stages, show symptoms of neuritis in opaque, dirty red disks, with venous congestion, peripheral contraction of the field of vision, with diminished acuity of central vision; in the latter stages we have a bluish-white atrophy. Förster has recently called attention to a characteristic scotoma for red, in cases of tobacco atrophy, showing an ovoid form with its longest diameter horizontal, and lying between the fixation point and the blind spot. I have not had an oppor-

tunity of examining a sufficient number of cases since my attention was called to this statement, to have an individual opinion as to its frequency, but in a case examined a few days since, such an ovoid scotoma was readily found on the position indicated; but the long axis of the ellipse formed an angle of about 45° with the horizontal line. There was also concentric diminution of the field of vision.

Atrophies following Loss of Blood.—Although perhaps not properly belonging here are most conveniently treated under this head. Transient blindness, complete or partial, may perhaps be due to anemia of the brain centres, or to partial and temporary palsy of the accommodation, but it is to those appalling cases of double atrophy of the nerves following hemorrhage, to which I here refer. Fries, in his monograph on the subject, gives many cases from the older authors where this has followed bloodletting, but the majority of the recently reported cases, where there have been ophthalmoscopic examinations, have followed hemorrhage either from the stomach or womb. The blindness may commence immediately after the loss of blood, but has usually been noticed from three to fourteen days after it. Jaeger gives two carefully examined cases of it, and the pictures which I now throw on the screen are copied from his atlas; and, show first, the blue degeneration of the nerve which was first observed in each case, and second, the atrophy of the retina and dirty-greenish hue of the nerve which developed in one of them, after severe headache coming on six years after the first examination. The nerve which was frequently examined during the interval had remained up to this time as first seen. Both of these cases were consequent on flooding in childbirth; in one of them the woman had four children, and at each birth severe flooding. The sight commenced to fail after the first hemorrhage, and got worse at each successive labor until she became completely blind.

Samelsohn, who has reported a number of interesting cases, supposes that, where the loss of blood is severe, there is great anemia of the brain, that it consequently

occupies less room in the skull, and that serum exudes from the vessels to fill the vacuum, and that as the patient regains strength and blood is reformed, the increased intracranial pressure drives the fluid into the subvaginal space of the optic nerves and causes neuritis. In other cases a hemorrhage into the sheath of the nerve is assumed as the cause.

For those very exceptional cases where after slight loss of blood there is complete blindness, with but slight changes in the nerves, retina, and prompt reaction of the pupils to light, we are obliged to assume some lesion of the optic centres; and Samelsohn attempts to explain it upon the observations of Luseana, Brown-Séquard, Ebstein, and Schiff, that wounds of the brain, especially the anterior prominences of the corpora quadrigemina and of the thalamus opticus, may cause hemorrhage into the mucous membrane of the stomach. Consequently he assumes a central lesion, which produces simultaneously the blindness and the hemorrhage.

All this is however but ingenious speculation, and the true pathology is still to be made out by careful autopsies. Of the changes in the eye ground in cases of *Insanity*, I have no individual experience. Such changes (paralytic retinitis and optic atrophy) are said to be most frequently encountered in paralytic dementia and the general paralysis of the insane.

With this I will close for the present my remarks on the alterations in the fundus oculi, which are symptomatic of other affections of the system or of disease of important organs, and will, at my next lecture, take up some of the local lesions of the eye-ground in disease limited to the eye itself, such as the changes in myopia, glaucoma, etc. I think I have said enough to convince you that the ophthalmoscope may be made an important aid in the diagnosis of disease in other organs of the body, as well as an aid in pathological investigation, and I hope that each one of you will leave the room determined to make it as constantly your companion as you will the stethoscope and the thermometer.

HOSPITAL NOTES AND GLEANINGS.

Case of Laparo-Elytrotomy.—M. M., aged twenty, primipara, of medium stature, rather fat and flabby habit of body, an ironer by occupation, was taken in labour on Friday, Nov. 22. 1878, about 6 P. M., and was admitted into the British Lying-In Hospital, under the care of Dr. ARTHUR W. EDIS, who furnishes the following report of the case:—

When seen by Mr. Fardon, resident obstetrician at Middlesex Hospital, about 11 P. M., she was in strong labour.

The pelvis was small: the head was felt with difficulty at the pelvic brim, the membranes being intact. Miss Thompson, a midwife, was left in charge of the case. About 4.30 A. M. on Saturday, November 23, the membranes ruptured, but the fetal head remained arrested at the pelvic brim.

About 6.30 A. M., Mr. Fardon being again called to her, gave chloroform, and endeavoured to apply the long forceps, but could not succeed in getting it to lock.

At 9 A. M., I was sent for. The os was then fairly well dilated, the head presenting at brim in the second position, right occipito-cotyloid. The patient had ankylosis of the right hip-joint, the thigh being considerably flexed.

On examination, the pelvis was found to be small and undeveloped, the diameter not exceeding two and a half inches antero-posteriorly. Before resorting to a more serious operation, as the head appeared to be of moderate size, the application of the long forceps was again attempted, but without success. At this time it was noticed that a huge thrombus was distending the right labium. It was then decided to remove her to the Lying-in Hospital, with the object of securing proper nursing, and other appliances, which were impossible in a room ten feet square.

At 11 A. M., a consultation with my colleagues, Dr. Heywood Smith and Dr. Fancourt Barnes, was held. Our unanimous opinion was, that delivery *per vias naturales*, owing to the contracted condition of the pelvis, and the thrombus in

the right labium, even after perforation of the fetal head and crushing by the cephalotribe, would be attended by extreme difficulty as well as danger.

The question of Cæsarean section or laparo-elytrotomy at once suggested itself; and bearing in mind the danger incidental to the former and the comparative success of the latter on the continent of America, it was decided to resort to this as giving the patient a better hope of recovery. The foetal heart was plainly audible to the right of, and a little below, the umbilicus: the head was felt resting in the right iliac fossa.

Operation.—At 11.30 A. M., chloroform, and subsequently ether, was administered by Mr. Fardon; the patient lying on her back, with her shoulders elevated. The carbolic acid spray was directed on the abdomen during the operation, and every antiseptic precaution observed. The bladder was emptied by means of the catheter. The uterus being drawn upwards and towards the left side, so as to put the skin in the right iliac region on the stretch, a slightly curved incision was made from a point about half an inch above and outside the spine of the os pubis, parallel to, and an inch above Poupart's ligament, to a point an inch above the anterior superior spine of the right ilium. The several structures met with were divided down to the transversalis fascia. This was then opened, Key's hernia director introduced, and the fascia cut. Any bleeding vessels were secured by Péan's hæmostatic forceps. The peritonæum was separated from the transversalis and iliac fasciæ, and a staff passed *per vaginam* to raise the vaginal *cul-de-sac* as much as possible into the abdominal wound. An incision was then made into the vagina on to the staff, parallel to the ilio-pectineal line, and the opening enlarged by tearing with the fingers. The os uteri was now drawn up towards the right iliac fossa, the long forceps applied to the presenting head, and the foetus extracted with very little difficulty.

It was a male, living, weighed seven pounds ten ounces, and measured twenty inches in length. The placenta was ex-

pressed through the wound; the uterus contracted well. But little hemorrhage occurred throughout the operation. On examining the wound carefully, the bladder was found to be torn somewhat on the right side. A catheter was fastened in, and the wound closed by silk sutures; a pad of lint and cotton-wool being then applied, and kept in position by a bandage.

The patient was much exhausted, but rallied fairly after a short time, every precaution being taken to promote warmth and obviate shock. She regained consciousness, and went on well for about thirty hours; urine passed freely through the catheter. The wound was injected with a weak solution of carbolic acid *per vaginam*, the water flowing out freely through the abdominal wound, the three inner stitches having been removed after the first few hours. None of the fluid entered the bladder, leading to the conclusion that the edges of the rent were in apposition. The nursing arrangements were most thoroughly carried out by the matron (Miss Freeman) and a staff of trained pupils.

About 8 P. M. on the 24th, she began to be restless, and showed symptoms of collapse. Wind was passed freely *per anum*, the abdomen being soft and flaccid; but no symptoms of peritonitis, or of extravasation of urine, supervened.

The temperature only once rose to 102.2 deg. Fahr. The pulse gradually increased in frequency, and, spite of every effort to the contrary, the patient gradually sank and died exhausted at 4.30 A. M. on the 25th, forty hours from the time of operation.

I had arranged everything for a careful *post-mortem* examination, but the husband and mother (Irish) objected so strongly to it, and evinced such fear of its being resorted to, that they insisted on the body being at once removed by the undertaker; consequently, my intentions were frustrated, and I am unable to lay before the profession the exact condition of the structures after operation.

Remarks.—My impression is, that the peritonæum was uninjured; there were no symptoms of peritonitis. Although the

bladder was evidently torn, this accident has happened in three other cases where recovery ensued; and I had no reason to believe that any infiltration of urine took place.

The patient was a flabby, unhealthy subject, with very defective rallying powers. The extremities were inclined to be cedematous, and became almost livid under the influence of chloroform.

Had Cæsarean section, or even cephalotripsy, been performed, my belief is that the issue would have been the same. She was emphatically an unsatisfactory subject for operation. The ankylosis of the right hip-joint complicated the operation somewhat, rendering it more difficult than would have otherwise been the case.

The child is living and healthy, and likely to do well. From what I have read of the experience of Dr. Thomas, of New York, as also of Dr. Skene, I believe the operation of laparo-elytrotomy will supersede that of Cæsarean section, and also, in many instances, that of cephalotripsy. —*British Med. Journ.*, Nov. 30, 1878.

Simple Epileptiform Neuralgia.—The patient was a porter, aged 42, well built, and in fair circumstances, who was admitted into the National Hospital for the Paralyzed and Epileptic, under the care of Dr. CHARLTON BASTIAN. His illness had commenced nine years previously with a swollen face after sleeping in a damp bed. During the early years, the pain does not seem to have been acute. The severe pain commenced in November, 1876, and continued, on and off, till July, 1877, with more or less severity. The onset was sudden; but the first attack was not so severe as some of the subsequent ones. At times, he was almost free from pain. In July, 1877, he had a severe aching pain in the position of the right infraorbital foramen; and in the evening of the same day he had an attack of pain in the supraorbital branch, shooting up over his forehead; this lasted from two to four minutes, and recurred in about a quarter of an hour. In this manner he suffered up till his admission to the hospital in November, 1877.

On admission, it was noted that he

suffered from epileptiform attacks of pain in the right side of his face, accompanied by increased secretion from the eye and the nose on that side; the attacks coming on about every fifteen minutes day and night, so intense and agonizing as to prevent him from doing anything except rubbing his face up and down at the seat of pain with a handkerchief during the whole period of his suffering. Each attack lasted from two to four minutes, those at night being usually the longer in duration. The pain began at the infraorbital foramen, and shot up to the eyebrow. The skin of the face was not over-sensitive; but, upon touching the supraorbital foramen, it was extremely painful, and brought on an attack of pain. The pain usually commenced in the right labio-nasal fold, sometimes just at the root of the hair. It did not extend beyond the supra-orbital branches of the fifth nerve and the superior maxillary, and never entered the mouth; he complained of constant throbbing at the infraorbital notch. Before the pain, there was no increase of cutaneous sensibility on the affected side; and when it passed off, there was no diminution. Between the attacks of pain, there was a saltish taste in his mouth. There was no twitching of the muscles of the face; but during the attacks the patient presented the aspect of extreme agony. In the intervals between the attacks, he was almost free from pain. Hearing and vision were good. Any movement or sudden starting on the part of the patient, as also forcible mastication, exposure to strong light, washing the face, or strong or sudden emotion, were sufficient to start an attack of pain. Over the infraorbital foramen, there was a puffy swelling. At the outer angle of the eyebrow, there was a boil, as also opposite the mental foramen. There was also an eczematous eruption covering the right cheek, probably due to the constant rubbing.

He was placed on full diet, and ordered one grain of opium in a pill three times a day. His general health was good when he could obtain good sleep; but he was frequently woke up from sound sleep by attacks of pain. The daily dose of opium

was increased gradually to nine, fifteen, and twenty-five grains during the first fortnight of treatment, and not till then was any relief afforded.

By November 27th—i. e., a week after he commenced the daily dose of twenty-five grains of opium—the frequency and severity of the attacks of pain had begun to diminish, and he was a little drowsy at times—not very.

December 5th. It was noted that the attacks of pain were less severe, so that he could speak during the attacks, which he could not do formerly; they were, however, of nearly the same duration. It was observed that, though touching the infraorbital foramen still brought on an attack at most times, this was not the case immediately after the pain had passed off.

During January, the opium was temporarily suspended; but, the pain returning, it was resumed. During February, the attacks of pain being much less severe, Dr. Bastian gradually reduced the daily dose of opium without the knowledge of the patient, until at last it was totally discontinued. By the commencement of March, the severity of the attacks had passed away; there was no pain whatever in the supraorbital region, and below the eye it was very slight, so that he desired to resume his occupation. He was discharged in March, 1878.

Remarks by Dr. Bastian.—From its rarity and peculiar characters, epileptiform neuralgia is a malady to which great interest attaches; and this case presents certain characters specially worthy of attention. In the cases observed by Trousseau, the duration of the attacks was often not more than ten or fifteen seconds, and he says, "one minute at the most." Here, unfortunately for the patient, the duration of the attacks was often two to four minutes, those of the night being rather longer than the day attacks. Trousseau makes no note of increased secretion from the eye and nose, and of suffusion of the conjunctiva and face during the attack, though these features were notable in the present case. The tactile sensibility of the face before and after an attack was carefully tested

on several occasions without showing any distinct difference; still it is noted (December 5th) that, whilst a slight touch on the infraorbital region usually at once induced an attack, this same region could be touched even roughly for a short time after an attack without inducing another. A central nutritional change seemed necessary before another attack could occur. As in Trousseau's cases, other causes of the slightest kinds sufficed to bring on attacks, such as chewing a little harder than usual at meal-time, or washing his face, or suddenly coming under the influence of a stronger light, or when feeling any slight emotional excitement. On the cessation of these attacks, the patient became perfectly free from pain. The quantities of opium taken by one of Trousseau's patients was enormous, varying from five to twenty drachms of crude opium in the twenty-four hours. My patient got almost complete relief from a maximum dose of twenty-five grains in the twenty-four hours, which scarcely produced any trace of day-drowsiness, and did not at all depress the general health. Looking to the nature of the malady, I thought it very important that the dose of opium should be diminished whilst the patient thought he was still taking it. Trousseau said that he had never known a single case of this terrible malady to be radically cured; nerve-sections or enormous doses of opium would at times stave off the attacks for three or four months, but then they returned as bad as ever. My patient was submitted to the opiate treatment comparatively early, instead of after years of suffering, so that his immunity from pain may be longer than usual.—*British Med. Journal*, Jan. 18, 1879.

—
Acute Eczema treated with Jaborandi.—Harriet T., aged 53, a cook, was admitted Sept. 14, 1848, to St. Thomas's Hospital, under the care of Dr. ORD. She was a fairly nourished, well-developed woman. The skin of the face was scurfy and irritable. Many eczematous patches existed on both arms and legs. The right leg was almost entirely covered with an inflammatory patch, with numerous weep-

ing spots, and studded with small yellowish points. Both ears also were affected. The itching of these parts was very troublesome. In other respects patient's condition presented no points of importance. Her previous history was that of a fairly healthy woman. About three years ago she had varicose ulcers on the left leg, soon followed by similar ulcers on the right leg. These were cured in about thirteen weeks, but broke out again in about two years. During the second attack she had eczema affecting both the lower extremities and the arms. She was then an inmate of this hospital, and was discharged cured in February last. About two months ago she began to feel an irritation about the legs. Five weeks ago there was weeping from the irritated surface, and she became an out-patient under Dr. Ord. Was finally admitted on above date.

Treatment—As local application a lotion of linimentum calcis with albumen was at first employed. Subsequently, on October 4, an application consisting of tinct. catechu and glycerine, each three grains, and water to sixteen ounces, was used. On October 12, tinct. jaborandi, a drachm in water twice a day, was ordered to be given internally. The following are the notes of the subsequent progress of the case:—

October 8. Legs are certainly better, but the irritation of the eruption on the arm is very great when patient becomes warm. She takes her food better than formerly.

14th. Patient is a good deal improved in general health, and as regards the affection of the legs and arms. The posterior region of the scalp and the back of the neck are now affected with eczema.

18th. Improvement continues. The dose of jaborandi has been reduced to half a drachm, given twice daily.

25th. The legs are now quite dry; the left calf is somewhat tender.

November 15. There has been a fresh attack, of an inflammatory character, of the right leg. The jaborandi has been discontinued for the present.

22d. The right leg is much better.

Patient is at present taking an iron mixture.

December 10. The jaborandi has been resumed to-day in half-drachm doses, given in three ounces of lime-water. The eczema of the back of neck and scalp does not seem to have been improving lately.

16th. The legs are looking clean and do not weep, but the skin is a good deal discoloured. The neck and scalp are much better, and are quite free from discharge. Patient's general condition seems improved.

Remarks.—From observations of the effect of jaborandi in this case, and in other cases of acute eczema, Dr. Ord believes it to be a drug of real value in that disease. It probably produces a hyperæmia of the skin which is favourable to the rapid removal of effete matters, and to an improved nutrition of parts. Very little good has been done in this country with jaborandi as a curative agent, and it will be interesting to know from further experience if it can be relied upon as useful in the treatment of this class of skin affections.—*Medical Times and Gaz.*, Jan. 11, 1879.

Retinitis Albuminuria; Improvement after

Premature Confinement; Remarks.—A woman aged thirty-six was admitted on April 18th, into the Westminster Hospital. Her husband was a strong, healthy man, in good circumstances. She had been married eight years, and had had two children; she was pregnant for the third time when she came under observation. There was no trace of syphilis or other inherited disease in her family history. She had enjoyed good health up to within a short time of her admission, with the exception of severe headaches. After an aggravated attack of headache, about the 1st or 2d of April, her eyesight suddenly became dim, and continued to fail day by day, so that on April 12th she applied to Mr. MACNAMARA at the Royal Westminster Ophthalmic Hospital, when, according to Mr. Mackinlay's notes, her vision was nil with the right eye; with the left she could make out No. 8 of Snellen's test-type at eleven

inches. The urine contained one-half albumen. In both eyes a number of small, raised, white patches were seen arranged concentrically around the upper and outer part of the optic disk, as well as scattered over the fundus of the eye; the retinal vessels could be traced over many of these spots; the margins of the disk were fairly well defined, the retinal veins slightly enlarged, and in many places bright spots of hemorrhage were seen in the retina. Large floating bodies were observed in the right vitreous.

On admission, she could only read No. XX Snellen at four inches; her head was so dizzy she was in constant fear of falling. Under these circumstances, as she was only six months pregnant, Mr. Macnamara urged her to go into the Westminster Hospital, and put herself under the care of Dr. Potter, in order that a premature confinement might be brought on, it being Mr. Macnamara's opinion that unless this means were at once adopted the sight would inevitably be entirely lost. There was also considerable risk of her dying of convulsions during confinement if pregnancy were allowed to run its natural course. The urine at this time contained three-quarters albumen, with a few large and some small faintly granular casts.

On April 27th, Dr. Potter brought on premature confinement, and under his treatment the patient made a very favourable recovery, so that she was able to leave the hospital on May 23d. The urine then contained only the slightest trace of albumen. Six months after she came under treatment she could get about, and perform her household duties. She was able to make out No. 15 Snellen with the right eye, and No. 11 with the left at six inches. No spots of hemorrhage could be detected in either eye, but the glistening patches remained in the fundus of the right eye; in the left they could no longer be seen. The urine contained only a trace of albumen, if any.

Remarks.—This is the third case of the kind Mr. Macnamara has met with, in which rapidly-advancing blindness during pregnancy with albuminuria has been arrested by premature confinement. In the first case the patient retained her

sight, and lived for seven years after her confinement, ultimately dying from disease of the kidneys. The second patient is still alive, and has fair sight five years after premature confinement. The case above recorded is the third. In this instance there could, Mr. Macnamara thinks, hardly be any difference of opinion as to the course to be followed, for this patient was pregnant only six months, and the disease in her retina was making rapid progress, so that in all human probability she would have become blind in the course of a short time. Moreover, there was less risk to her life during a premature confinement than in labour if pregnancy had been permitted to run on until the ninth month. But in cases of this form of retinitis, in which the sight commences to fail during the seventh or eighth month of pregnancy, the question of a premature confinement is an extremely difficult one. As a rule, the risk under any circumstances is considerable, but the danger to life from convulsions during confinement is generally greater the longer the birth of the child is delayed.

With reference to the sight, every week the confinement is postponed, after symptoms of rapidly-advancing retinitis have declared themselves, the greater the risk of permanent loss of vision, for the destructive changes in the retina are apt to make sudden, frequently rapid, and irrecoverable strides in cases of this kind.—*Lancet*, Dec. 14, 1878.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Pneumonia at Bellevue Hospital, New York.—Ten years ago pneumonia was quite uniformly treated with carbonate of ammonia internally and an oiled-silk jacket externally. The carbonate was given in doses of gr. v every three hours, or sometimes gr. x three times a day. The muriate was occasionally substituted. Gradually quinine came to be combined with the ammonia, while now quinine has quite taken its place in many wards. The quinine is given in doses of gr. x three times a day, increased or diminished according to the fever. The

oiled-silk jacket is still continued, and if there is much pain in the side, a coat of iodine is ordered. This, with an absolutely recumbent posture, is all that is enjoined in many cases. Aconite has been used in five cases, of which one died. It is given in doses of mj every hour, till some effect of the drug in relief of dyspnoea, fever, or production of sweating is produced.

In forty-four cases quinine was used with good results. The method of administration is varied. Besides the routine mentioned, it is given gr. j every hour, or grain v every four hours, and often, as directed by the Juergesen, gr. xl or gr. l in one dose, then discontinuing it for a day or more. The antipyretic effect of quinine is not sufficiently marked to have made it clear which is the best way. Cold sponging has been employed with quinine. Of seven cases so treated, three died. The gradually cooled bath has been used, and at once given up.

Owing to the previous bad habits and bad condition of the patients, as well as to the frequent virulence of the disease, the treatment of many cases of pneumonia soon resolves itself into the treatment of exhaustion, oedema of the lungs, and a nearly moribund condition.

How to carry a patient through critical conditions of this kind, how much stimulus, and what kind, are matters that textbooks do not give very definite accounts of, and experience has generally to become the teacher.

Many cases that come into the hospital have a record like the following: The patient is a tolerably strong man, in the third day of the fever. He has a temperature of 104° , respiration 50. His pulse is very good, and he feels pretty comfortable. He is given milk and eggs, and gr. xv of quinine. This is in the morning. In the afternoon he is weaker, his face is a little blue, he breathes faster. On listening to the lungs, moist râles, fine and coarse, are heard. He is beginning to have oedema. He is at once dry-cupped for fifteen or twenty minutes, during which time 150 cups are put on. The oedema has now disappeared. He is ordered mx of tr. digitalis every three

hours, and Zss of whiskey every two hours, with milk and eggs. He continues better for some hours. Towards evening the oedema again shows itself. He is again cupped, and gr. x ammon. carb. is ordered every two hours, alternating with the whiskey. Again the oedema clears up. In addition, a can of oxygen is ordered for the night, and the patient inhales it for fifteen minutes in every hour. This relieves his dyspnoea. But towards morning the cyanosis and oedema again appear. The cups are applied again, and the whiskey ordered. Zss every hour, alternating with the ammonia, gr. x every hour. By these measures he is carried through the night, and in the morning is easier. Nourishment in the form of milk is still kept up. He is not allowed to sleep continuously, for during sleep the oedema comes on. By such fighting as this, the greatest reliance being placed on whiskey, milk, and dry cups, a patient is occasionally brought through. If, on the following day, he is still worse, the resources in the way of stimulants are not exhausted. Other forms of ammonia are used. Hypodermic injections of camphor dissolved in sweet oil are given every three hours in four-grain doses. If the patient has persistent oedema and a full pulse, venesection is tried, and is invaluable when digitalis and cups no longer avail. The oxygen cannot be pushed too much, as it causes unconsciousness.

Hypodermic injections of ether to the amount of one or two drachms sometimes bring up the pulse. Teaspoonful doses of champagne every five minutes will help to tide a crisis. There is a limit to stimulation, of course. When Zss of whiskey every half-hour has no effect, the patient will die. There is no use in increasing the amount unless it is desired to preserve the stomach afterwards. In the case of a man to whom Zss q. $\frac{1}{4}$ h. was given for several hours, the stomach was found at the autopsy to be considerably hardened by the alcohol, and to smell strongly of it.

In spite of all efforts, most of the cases in which oedema of the lungs occurs go on from bad to worse. The extremities be-

come cold and wet with perspiration; hot bottles applied to them and to the breast, mustard to the epigastrium, accomplish only temporary good, the patient has long been stupid; he now loses consciousness, his breath is slow and laboured, the air-passages are full of serum; gradually the respirations grow slower and slower, and finally stop. The patient dies. At the autopsy part of the lung will be found to have reached the stage of gray hepatization.

It will be seen that no new or specific treatment can be deduced from these cases. It has become a firmly rooted belief that quinine is a good thing to give, and in those so treated the mortality has been somewhat diminished. The class of patients is not one upon which cardiac sedatives can be fairly tried.—*Medical Record*, Feb. 1, 1879.

Medical Society of the State of New York.

—The seventy-third annual meeting of this society was held at Albany on the 4th, 5th, and 6th of February, Dr. D. B. St. John Roosa, of New York, President, in the chair. The meeting was largely attended. A number of papers of great interest and merit were read. The following officers were elected for the ensuing year: President, Dr. Henry D. Didama, of Syracuse; Vice-President, Dr. Nathaniel C. Husted, of New York; Secretary, Dr. Wm. Manlius Smith, of Onondago County; and Treasurer, Dr. Charles H. Porter, of Albany. The next meeting will be held at Albany, on the first Tuesday in February, 1880.

New Medical Journals.—The following journals have been ushered into existence with the new year:—

The American Journal of Otology, a quarterly journal of physiological acoustics and aural surgery, edited by Dr. Clarence J. Blake, of Boston. The first number contains 80 pages, one-half of which are devoted to original articles, and the remainder to book notices, and a review of the progress of otology and acoustics. The original papers are from the pens of Drs. Blake, Burnett, A. H. Buck, and Sexton, and their names are a guarantee of the value of their contributions.

The first number of the *Index Medicus* has been published. It redeems the promises of its publisher's prospectus, and justifies all that we said of it in our January issue. It is handsomely printed in clear type, on heavy paper.

The *St. Louis Courier of Medicine and Collateral Sciences* is a monthly journal of 120 pages, edited by Dr. A. J. Steele, of St. Louis. Its contents are varied, embracing original communications, societies' proceedings, editorials, correspondence, and extracts from other journals. The first two numbers that have been published are alike creditable to the editor and to the Medical Journal Association of Missouri, under whose auspices it is published.

We have received from G. P. Putnam's Sons, the prospectus of the *Archives of Medicine*, a bi-monthly journal, to be edited by Dr. E. C. Seguin, of New York, and designed to be a continuation of the "Archives of Scientific and Practical Medicine," and of the "American Clinical Lectures." The first number is advertised to appear in February.

FOREIGN INTELLIGENCE.

Protracted Epistaxis Caused by a Parasite.

—Dr. LANDON, of Elbing (*Berl. Klin. Wochenschrift*, No. 49, 1878), relates the case of a workman, aged forty-two, who soon after the Franco-German campaign of 1870 was laid up with pain in the hepatic region, jaundice, and gastric disturbance, which symptoms persisted more or less until 1874, when he came under Dr. Landon's care with an attack apparently of perihepatitis. It then appeared that since 1871 he had also suffered from severe attacks of epistaxis, which occurred often twice in the same day. The patient complained of a feeling of painful pressure in the left nasal cavity, but with the speculum nothing but a moderate degree of inflammatory swelling could be detected. Suddenly, at Easter, 1878, a parasite was dislodged from the left side of the nose by a violent sneeze, and from that moment the epistaxis has not occurred. Its cause proved to be the *Pentastoma tanioides*, a fluke which in the

perfect state inhabits the frontal sinuses and nasal cavity of dogs and other carnivora, occasionally of horses and goats, and in some countries of the human subject (Leuckart Küchenmeister). The embryos live encapsuled in the pleural and peritoneal cavity of some herbivorous animals, and invade the liver. After a time they pierce the capsule and wander in the body of their host, finally, unless he dies meanwhile, again becoming encapsuled. If the flesh of the host is eaten uncooked, the flukes find their way in the second host to his nasal and frontal sinuses, where they remain. It is not known how they enter man, but they are found in the liver of the negro. In the present case the hepatic symptoms were clearly traceable to the presence of *pentastomata* in the liver, and their cessation is probably due to the encapsulation of the parasite.—*Med. Times and Gaz.*, Jan. 4, 1879.

Inhalation of Oxygen in Albuminuria.—Dr. DUJARDIN-BEAUMETZ inquired of his colleagues of the Société de Thérapeutique (*Gaz. Hebd.*, January 17) as to the results of their experience in treating albuminuria by means of oxygen. He related a case which had reached its last stage, all means having been tried in vain, when the respiration of oxygen was had recourse to. The albumen disappeared completely during the first twenty-four hours of its employment, and although this disappearance will probably prove only temporary, twelve days have passed without any return. Dr. Constantin Paul replied that he had published two analogous cases, in which, under the use of oxygen, the albumen disappeared, but in two months it returned as bad as ever. Similar cases have since been published, and the most that can be hoped for from this means is a comparatively long remission. M. Greletty observed that at Vichy it has long been the practice to administer oxygen both for diabetes and albuminuria, and as a general rule a diminution in the amount of albumen or sugar is observed; but the disappearance is not found to be total, and in all cases is only temporary.—*Med. Times and Gaz.*, Jan. 25, 1879.

Death from Chloroform.—This unfortunate occurrence took place last Friday in Prof. Dumreicher's Clinic in a person to whom chloroform was administered preparatory to an operation for hydrocele. He suddenly expired after the inhalation of from fifteen to twenty grammes of pure chloroform. Every means of recovery, including tracheotomy, were tried in vain. At the autopsy nothing remarkable with respect to the organs of respiration and circulation was found.—*Med. Times and Gaz.*, January 25, 1879, from *Allg. Wien, Med. Zeit.*, December 24.

A New Test-Paper.—M. LACOUR (*Recueil de Méd. Mil.*, August) prepares this by adding to rhubarb double its weight of liquid ammonia, which produces a magnificent red-purple. After a quarter of an hour the liquid is separated by filtering, and strips of filter-paper dipped in it are then dried. Under the influence of acids the paper becomes a lemon-yellow, and with alkalies it regains its former colour. It is a very sensitive test.—*Med. Times and Gaz.*, Nov. 30, 1878.

Laceration of the Diaphragm from Distension of the Stomach.—In Eulenburg's *Vierteljahrsschrift*, Band xxix., is related the case of a man, about thirty years of age, who having eaten a large quantity of food containing vinegar, and taken after it repeated doses of bicarbonate of soda, was seized with violent pain in the abdomen and faintness, and died suddenly. An autopsy having been made, under the suspicion of poisoning, a rupture of the diaphragm, about twenty-five centimetres in length and fifteen in breadth, was found, detaching the diaphragm from the right side of the ribs to the spinal column, and allowing the passage of the intestines and liver into the right cavity of the chest. The stomach resembled an immense bladder distended with gas. The half-digested food had been inspired into the air-passages in large quantities.—*Med. Times and Gaz.*, Feb. 1, 1879.

Transplantation of Teeth.—A remarkable experiment in the transplantation of teeth

is recorded in the *Gazette des Hôpitaux*, No. 2, 1879. On July 30th, M. Pietkiewicz extracted an anomalous right lower lateral incisor which grew under the tongue in a young woman of twenty-six, and planted it in the upper jaw on the same side, in the alveolus of the lateral incisor, which he had just removed for extensive caries, and which was rotated congenitally on its axis. At the same time, by a special apparatus exercising constant pressure, he was able to bring back the right inferior canine into line. In spite of an accident, six weeks later, the experiment succeeded perfectly, the tooth becoming fixed with great firmness. It has been long known to be possible to replace a tooth just removed by another similar to it in regard to age, volume, form, etc., if recently extracted. Indeed, Professor Alquié, of Montpellier, showed, in 1858, that a carious tooth could be replanted after resection of its decayed portion. But it is pointed out that, in M. Pietkiewicz's case, there were very remarkable anatomical differences between a lower and upper lateral incisor. The root of the former is finer, and flattened transversely and grooved; that of the upper is fuller and rounded. In fact, the fang of the lower by no means filled the upper alveolus, while at the same time it was considerably too long for it, requiring removal of a third of the crown to bring the edge into line with its neighbours. In spite of all this, the success was perfect, and suggested to the surgeon mentioned the possibility of utilizing anomalous teeth for transplantation, even to replace others not anatomically analogous to them, the difference in shape being remedied by cutting and shaping with instruments. The teeth of other mammalia might also, perhaps, be successfully employed for the same purpose.—*British Medical Journal*, Feb. 1, 1879.

A Foreign Tribute to Dr. Peaslee.—Dr. CHARLES WEST, in his Presidential Address before the Obstetrical Society of London (*Obstetrical Journal of Great Britain*, Feb. 1879), pays the following handsome tribute to the lamented Peaslee:—

"My task is nearly done, and I have but

to make mention of two more of our fellows, who held the distinction of our Honorary Fellowship, Dr. Fleetwood Churchill, and Dr. Edmund Peaslee; two men, who though widely different in character, had in common unwearied diligence and unselfish aims, and met their well-deserved reward, not in success only, but in the respect and affection which attended them when living, and which follows their memories now that the grave has closed over them."

Dr. West then gave a brief biographical sketch of Dr. Peaslee, and thus concluded: "Edmund Randolph Peaslee's great claim to our Honorary Fellowship, and the work on which his reputation rests, was his treatise on ovarian tumours and ovariectomy, published in 1872. The book merits and has received very high praise. It is systematic, clear, candid, and takes account of every question which can arise with reference to ovarian disease. The conclusions at which the author arrives are controlled, in large measure, by his own experience, and are always sound and moderate, but, of course, the writer, the total number of whose cases of ovariectomy amounted at that time to only twenty-eight, cannot adopt as decisive a tone as another whose cases are counted by hundreds. Dr. Peaslee's fame, already high, was greatly extended by the publication of this book, and with increased fame came also large increase of practice. There seems, indeed, but little doubt, that his premature death, at the age of 64, was in a great degree owing to the incessant overwork which his practice forced upon him. It was his great good fortune that remarkable as his success was, it yet in his case stirred no enmities, for he seems to have had a special power of personal attraction which drew to him all with whom he came in contact; a charm which our friend, Dr. Barnes, tells me that he felt powerfully on his own visit to America. . . . To have merited and gained so high a name, and such large success, yet never to have stooped to what was unworthy, to have kindled no jealousy, excited no envy, is a happiness which falls to the lot of very few, and is in itself the highest praise."

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